UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

REQUEST FOR INJECTABLE ANTIBIOTICS
For Non-Traditional Clients

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO (801) 536-0477

CRITERIA FOR INJECTABLE ANTIBIOTICS:

- Injectable antibiotics and diluents associated with the preparation and administration of injectable antibiotics are available under the following circumstances:
    - Continuation of treatment that was started in the hospital,
    - Documented diagnosis of cellulitis,
    - Documented diagnosis of osteomyelitis.
- Prior Authorization request MUST include an anticipated duration of therapy.

NOTES:

This request form is to be used only for Non-Traditional Medicaid clients (blue card). Traditional Medicaid clients (purple card), in general, do not require clinical prior authorization for IV antibiotic therapy.

AUTHORIZATION:

Prior authorization will be granted for the requested duration of therapy.

RE-AUTHORIZATION:

Telephone call from the physician's office or pharmacy to (801) 538-6155, option 3, 3, 2.